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Gonococcal perianal abscess: re-emergence after cessation of co-trimoxazole

We report a case of perianal abscess due to *Neisseria gonorrhoeae*, which appears to have been suppressed but not eradicated by chronic low dose co-trimoxazole for a period of almost 6 months between acquisition and diagnosis.

The patient was a 34 year old HIV infected homosexual man treated with didanosine, stavudine, and nevirapine with a HIV viral load of 500 copies per ml and a CD4 lymphocyte count of 280 × 10^6/l. He was taking co-trimoxazole 400 mg/80 mg once daily to prevent *Pneumocystis carinii* pneumonia (PCP).

He reported last having receptive anal sex in June 2000. This was unprotected, with a casual partner at a "gay" sauna. Three weeks later he reported a perianal abscess which discharged spontaneously, requiring dressings for a few days. A sinus was observed and he was booked for elective surgery. He remained well for 5 months.

Co-trimoxazole PCP prophylaxis was stopped in November 2000 as his CD4 T lymphocyte count had remained above 200. Two weeks later (and almost 6 months after the last reported anal sex) he presented with purulent discharge emerging from a sinus approximately 3 cm from the anus.

N gonorrhoeae (sensitive to penicillin, ceftriaxone, and ciprofloxacin) and *Bacteroides* species were cultured from this discharge. Swabs from the rectum, throat, and urethra as well as urine were negative for *N gonorrhoeae* and *Chlamydia trachomatis* by polymerase chain reaction (PCR).

Oral ciprofloxacin was started but pain, swelling, and perianal cellulitis led to his admission to hospital where he was treated with intravenous ceftriaxone and metronidazole and surgical drainage.

Gonococcal perianal abscesses were reported in the pre-antibiotic era[1] but have disappeared from contemporary descriptions of gonorrhoea, whereas Bartholin's, periurethral, and tubo-ovarian gonococcal abscesses are described.[2]

The isolation of *Bacteroides* species and the worsening of the infection despite ciprofloxacin suggest that anaerobic organisms probably played a part in the development of an abscess, consistent with animal inoculation experiments.[3] Another possible factor was the moderate immunosuppression (CD4 count of 280) from his HIV infection.

Six months passed from the time of infection to diagnosis, during which the patient was largely free of symptoms which then developed when co-trimoxazole was stopped. The likely explanation is that the co-trimoxazole was suppressing the gonococcal infection without curing it. The failure to detect *N gonorrhoeae* by PCR from the rectal specimen raises the possibility that co-trimoxazole may have eradicated a rectal infection in this case while only suppressing an extragenital manifestation.

It is now standard practice to stop PCP prophylaxis when CD4 counts rise above 200 × 10^6/l in patients taking antiretroviral therapy.[4] This may in turn have some impact on both the transmission and the manifestations of gonorrhoea in these patients, perhaps even contributing to increases in gonorrhoea in HIV infected populations.[5]

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Uptake of HIV testing in patients with a confirmed sexually transmitted infection

UK seroprevalence rates indicate that up to 50% of HIV positive patients in genitourinary medicine (GUM) clinics remain undiagnosed.[1] HIV is mainly identified in high risk patient groups. Sexually transmitted infections other than HIV (STIs) have been shown to facilitate and be associated with enhanced HIV transmission.[2] Risk assessment for HIV, therefore, should target patients with an STI or history of recurrent STIs as a high risk group.

Targeting these patients to test for HIV at the time or 3 months after their STI diagnosis, is important as it will lengthen the "diagnosis interval" of patients testing HIV positive thereby conferring a better outcome, with respect to HAART[3]; identify patients with recent concurrent acquisition of HIV and a STI, entering a highly infective seroconversion phase; identify individuals with undiagnosed, established HIV infection and a newly acquired STI which promotes higher infectivity due to increased HIV viral shedding into genital secretions.[4 5]

Our study analysed the uptake of HIV testing among attendees who had a genitourinary screen at St Thomas's Hospital genitourinary medicine department between 1 and 31 December 1999.

It compared the uptake of HIV testing, either at the index visit in December or deferred to within the ensuing 3 months, between patients diagnosed with an STI (gonorrhoea, chlamydia, herpes simplex virus, and trichomoniasis (study group)) and patients receiving a negative STI screen (control group).

Of 318 attendees, 242 and 76 patients comprised the study and control groups respectively. Only 18% (59/318) of patients tested for HIV on the initial visit. Significantly fewer of the study group tested for HIV (14%) compared to the control group (33%) ($p<0.01$).

Of those who did not test for HIV, 11 and one patients deferred testing in the study and control groups respectively (table 1) However, none of the deferrers or initial non-testers re-attended for HIV testing in the following 3 months.

In view of this unacceptably low rate of HIV testing, both overall and in those patients with a confirmed STI, the following interventions are now being introduced, aiming to improve these figures and comply with the sexual health strategy 2001 targets.[6]

- An "opt out" policy of HIV testing
- Additional waiting room posters and a new patient information leaflet about HIV is given to all patients at registration to read while they wait to be seen explaining the natural history, treatments available, benefits of early diagnosis, and mechanisms of reducing transmission. This enhances patient education and may expedite consultation length and waiting times for patients with restricted "time off" and/or other more pertinent issues to discuss
- Pretest counselling is reserved for high risk groups instead of being required routinely
- Patients are able to obtain their HIV results indirectly, without the inconvenience of a previously required second visit
- Educating all GUM staff to encourage a high offer rate of HIV testing to all patients, especially targeting high risk patients, which incorporates those with a confirmed STI.

Table 1 Timeliness of HIV testing

	Tested for HIV at time of attendance	Deferred at time of attendance	Attended within 3 months and tested for HIV
Study	34/242 (14%)	11/242 (5%)	2/46 (4%)
Control	25/76 (33%)	1/76 (1%)	2/11 (18%)

Contributors
SD, CAR, and DL designed the study; SD and DL gathered and statistically analysed the data; SD, DL, and CAR contributed to writing the paper.

Conflicting interests: There were no conflicting interests and no costs incurred.

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BOOK REVIEW

The Changing Face of HIV and AIDS. Scientific editors: Robin A Weiss, Michael W Adler, Sarah L Rowland-Jones. *British Medical Bulletin* 2001, Vol 58. Pp 223; 40. Published for the British Council by Oxford University Press. ISBN 0199224862.

Not many books nowadays try to summarise the broad field of HIV and AIDS. This *British Medical Bulletin* does attempt to do that, in line with its usual approach to providing substantial coverage of health subjects, but with suitable depth as well as breadth. The last (and first) *British Medical Bulletin* on this subject was published in 1988. It covered quite similar topics, but the main change is the depth of knowledge.

Although the title of this volume reflects the general sense that the face of the pandemic has indeed changed in many ways—not least the global spread, and the impact of antiretroviral therapies where they are available—the overwhelming impression I had was how similar are the issues and perspectives it covers. This is partly a reflection of the extraordinary hothouse atmosphere of the early pioneering years, when we climbed the steep part of the learning curve with unparalleled speed. The subsequent years have been ones of consolidation, during which the detail has been explored and the basic ideas refined. This book reflects that, where the change in the face is in part the shift from an impressionistic image to a more fully representational portrait, evidently from the same original.

The chapters provide a balanced and compact, yet thorough, assessment of the main issues. The authors are active in the field; they have an appropriately British background for this series, yet their perspective is unequivocally global. The accounts are worthy, reliable, and authoritative. If this conveys the impression that they are rather dull to read, that was indeed my feeling. There was generally and disappointingly little sparkle or originality in the concepts or the writing. Where there was, it derived from a narrow focus on a small part of the canvas rather than any broader insight.

Who will use this volume? I would recommend it as a reliable and thorough review for a new entrant to the field. Those who work adjacent to it and who would like a compact, up to date summary would also be well served. Some of the chapters are an excellent springboard for detailed exploration of their topic. But those who already work on HIV/AIDS will find little to engage or excite them. They would probably feel, as I did, that the fascinating wider changes in the actual face of HIV/AIDS, which are palpable in their work, have scarcely been touched upon.

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NOTICES

International Herpes Alliance and International Herpes Management Forum

The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American Health Organization, regional office of the World Health Organization

A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tsp.sheridan.com).

26th National Conference of the Indian Association for the Study of Sexually Transmitted Diseases & AIDS

18–20 October 2002, All India Institute of Medical Sciences, New Delhi, India
The last date for submission of abstracts for free papers is 1 September 2002. The registration fees for foreign delegates is $50 (SAARC countries) and $100 (other countries).
Further details: Indian Association for the Study of Sexually Transmitted Diseases & AIDS (fax: (0)91 011 686 2663; email: iasstd2002@sify.com).

European Society for Gynaecological Endoscopy Expert Meeting on Pelvic Floor Disorders

28–30 November 2002, Centro Médico Teknon, Barcelona, Spain
Further details: ESGE central office, Orga-Med, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2582 0852; fax: +32 2582 1515; email: orgamed@village.uunet.be; web site: www.ESGE.org).

Royal Society of Medicine Conference on Men's Sexual Health

13 December 2002, The Royal Society of Medicine, 1 Wimpole Street, London, W1G 0AE, UK
Is Viagra really the answer to impotence, or are men and their doctors relying on prescription pills and avoiding tackling the psychological causes behind the problem? Besides impotence and other sexual dysfunction, this meeting also looks a range of male sexual problems from STDs to prostate cancer, the effect of sex on the heart to the male menopause. Registration costs: Fellow: £105; Non-Fellow: £175; Student: £20. CPD: 5 credits; PGEA Applied For.

Further details: Ms Georgina Brodie, RSM Administration (tel: +44 (0) 20 7290 3856; fax: +44 (0) 20 7290 2977; email: georgina.brodie@rsm.ac.uk).

XIX International Congress of the Society of The Fetus as a Patient

1–4 May 2003, Gran Hotel Sitges, Barcelona-Sitges, Spain
Further details: (fax: +34 93 418 7832; email: bcn2003@iudexeus.uab.es).